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How should community pharmacists be paid under the new contract?

In this article, **Darrin Baines** and **Catherine Hale** examine how primary care trusts in England could reimburse local pharmacies in order to help meet the Government's evolving agenda for pharmacy and the NHS.

Previously in The Journal 1 we discussed the economics of the new pharmacy contract. We suggested that the proposals currently under discussion will alter the economic arrangements facing community pharmacists. For instance, we reported that the “dispensing fee” for distributing the national “global sum” will be abolished and pharmacy monies will be channelled through local, primary care trust “unified budgets”. Although PCTs will be able to purchase essential, advanced and enhanced services using monies from their unified budgets, it is not clear what mechanisms trusts will use to reimburse pharmacy providers. In theory, budgets, incentives, costing models, resource allocation formulae, outcome guarantees, health-related groups and activity-based management could all be used to distribute pharmaceutical funds.

Although a wealth of options exists, the contract negotiators have not publicly debated the costs and benefits of different payment systems. In response to this failure, this paper examines how PCTs could reimburse local pharmacies in order to help meet the Government's evolving agenda for pharmacy and the NHS.

Old problems, new principles

According to the Department of Health, the current arrangements for remunerating pharmacists are problematic because they:

* **Emphasise workload rather than quality and accessibility of services**
* **Treat all pharmacies the same, irrespective of service range and quality**
* **Reinforce the belief that dispensing is the hallmark of a successful pharmacy**
* **Do not encourage reduced dispensing of unnecessary prescriptions**

Against this background, the Government wishes to develop a new, patient-focused contract that directs payments towards quality, not dispensing volumes[2]. In developing a new remuneration framework, the DoH outlined the following targets that should govern the commissioning of pharmacy services:

* **Easy access to services, supported increased choice and competition**
* **Best use of skills of pharmacist and support staff**
* **Flexibility and continuous improvements in services provided**
* **Quality improvements driven by governance and performance management**
* **Continuous development of the skills of pharmacists and support staff**

In economic terms, this list is highly ambitious, as the Nobel prize-winning economist Tinbergen found that for each policy target, governments must have at least one policy instrument, and policy instruments must be effective for achieving policy targets. In this context, Tinbergen's work implies that the new pharmacy contract should contain effective policy instruments that directly deliver the Government's access, skill-mix, flexibility, quality and skills targets.[3]

To this end, the DoH stated that the new framework should:

*** Provide clear minimum standards for community pharmacy**

*** Provide clear and fair rewards for high quality, value for money services**

*** Harness skills to deliver better primary and community care services**

*** Develop opportunities and rewards for integrated working**

As this list suggests, the Government intends to use a mixture of rewards, standards and policy as instruments to meet its policy objectives.

In response, this paper examines how different payment mechanisms could be used, alongside governance and priorities, to deliver the Government's aims.

Essential difference

In terms of provision, the new contract is structured around the three, hierarchal categories of essential, advanced and enhanced services. At the lowest level, essential services are non-negotiable tasks that all contractors must perform, which include dispensing, signposting, clinical governance and the like. Although it seems appropriate for modern pharmacy, from the perspective of economics and law, the chosen list of essential services is interesting since it defines the obligations pharmacists must fulfil for their core income.

Just as family doctors outlined their “core” and “non-core” services in 1996, the new contract paves the way for pharmacists to charge PCTs for non-essential services, which may now be funded with dispensing or non-NHS fees.[4]

For GPs, the decision to define their core business paid dividends in the longer term, since the new general medical services contract reduces their obligations and increases their fees. Although an essential list could also benefit pharmacists, PCTs may suffer because they may have to finance services previously funded by pharmacists themselves.

Essential funding

Although details are vague, funding for essential services may be based upon information collected during the Pharmaceutical Services Negotiating Committee/DoH “cost of service” inquiry, which surveyed 470 contractors at the end of June 2003. In the survey, current staff, property and overhead costs were measured, which implies that these variables will form the basis of any subsequent funding formula. Although accountants regularly separate company spending into capital and current categories, economic theory suggests that costing models should not be used to allocate resources within the NHS.

First, models that reimburse costs usually contain no incentives for providers to control spending or to maximise efficiency. Secondly, cost models promote “historicism” in funding in the sense that past spending levels are used to determine future reimbursement levels.[5] Thirdly, cost-based formulae often fall foul of the “naturalistic fallacy”, that is, they wrongly attempt to say “what should be” from “what is”.[6] Finally, cost models tend to fund inputs (such as staff costs) not outcomes (such as improved access), which goes against the primary reason for a new contract.

As these criticisms suggest, any funding model based upon previous staff, property and overhead costs is likely to promote the status quo, not innovation, integration and change.

In response, we recommend that:

*** PCTs use “hard budgets” instead of cost formulae to limit pharmacy spending[7]**

*** Operating costs are recalculated in premises using a "shadow" new contract**

*** Core principles (such as improved access) become essential for all providers**

*** Activity based management should be used to link costs and outcomes[8]**

By following these recommendations, PCTs could divert money away from dispensing towards the delivery of the national targets for pharmacy. For instance, activity based management could be used to increase funding for providers who plan to meet the Chief Pharmaceutical Officer's 10 key roles.

Although we favour this approach, special arrangements should be made for pharmacies specialising in low-cost, high-volume dispensing, as described in paragraph 3.16 of the Vision document. These "efficient dispensaries", which will not provide essential services as specified above, should be funded on the basis of competitive tendering by PCTs, with the lowest-priced bidders winning local contracts.

Advanced services

In the second category, the new contract lists advanced services, such as medicines use reviews and prescription intervention services. Under the proposed arrangements, these services will require accreditation of the pharmacist providing the service or specific requirements to be met with regard to the pharmacy premises, or both. Although the logic for promoting such services is clear, in economic terms four main issues arise.

First, it is not clear why the provision of these services requires accreditation, particularly since the literature on this subject does not specify that this type of regulation is essential. Given the lack of clinical justification, economic theory suggests that accreditation is being used to create a monopoly to protect pharmacy incomes, which goes against PCT value for money objectives.

Next, economics suggests that accreditation could increase the "transaction costs" of providing these services, with increased NHS and pharmacist spending.[9] For instance, pharmacists and pharmacy owners may have to finance extra training and registration, and trusts may have to fund registration and policing.

Thirdly, funding for advanced services should not be ring-fenced solely for pharmacists, since this reduces the possibilities for integration with other primary care services.

Finally, the new contract does not specify which remuneration mechanism should be used by PCTs to fund such services, although pharmacists may be expecting sessional or fee-for-service payments.

In response to this last point, we suggest that advanced services be remunerated in one of three ways:

1. Cash-limited, hard budgets allocated on the basis of patient needs

2. Health resource groups could be established for these services[10]

3. Strategic health authorities could hold "incubator" funds to promote innovation

With the first policy instrument of hard budgets, the policy objective of needs-based, spending control would be secured; with the second suggestion, efficiency would be promoted. However, the third proposal may be the most interesting, if strategic health authorities use an "incubator" system to fund innovation in the ways medicines are managed.[11] In such a system, pharmacists could bid for special project monies to innovate or integrate their services under the supervision of mentors and experts in the field of pharmacy entrepreneurship. With this scheme in place, the new contract would move away from an emphasis on giving pharmacists more things to do and begin to deliver the targets outlined in the Vision document.

Top service

The highest level of the new contract focuses on a wide range of enhanced services, including those for minor ailments, diabetes, substance misuse, coronary heart disease and an innumerable list of others. In theory, pharmacists will offer these services, and PCTs will commission them on the basis of local needs.

Although theory is fine, five points should be held in mind:

1. PCTs have a duty to avoid duplication in service provision[12]

2. Money for these services will not be ring-fenced just for pharmacists

3. Enhanced services are activities with no specified outcomes

4. Traditionally, these activities would have been done elsewhere in primary care

5. None of the activities links to NHS or pharmacy, national or local priorities

In response, we suggest that few PCTs will make the provision of these activities a high priority, unless they have been identified as such in their three-year plans. If these services are required, the issue of duplication arises, which suggests they should be delivered in general practice premises, not local pharmacies. To add to this line of argument, current regulations and funding arrangements give PCTs the ability to buy these services from pharmacists now, without waiting for the arrival of a new contract. Therefore, this category is not actually needed, since it simply adds extra bureaucracy to service commissioning.

However, if the enhanced category stays, PCTs should avoid sessional or fee-for-item payments, and should pay pharmacists under hard budgets with “outcome guarantees” that pay for results, not activities.[13]

Implementation

During the first stage of contract negotiations, attention was focused on developing a framework for the new contract. If the metaphor of building a house is used, during the initial phase the negotiators acted as architects designing their contract plans. As the plans were approved by pharmacy contractors in October 2003, both sides are now negotiating an appropriate budget for the scheme. Once this second stage has been completed, the hard work of building the dream begins.

As the above metaphor suggests, the process of constructing a new pharmacy contract will soon enter the implementation stage. Once this phase begins, the strengths and weaknesses of the new design will become apparent. On the plus side, PCTs may find they have more control over pharmacy monies and contractors may find greater flexibility to pursue innovation and change. On the other hand, some contractors may wish that their negotiators had agreed a minimum income floor like the doctors, since their NHS revenues may fall under the new arrangements.

Although good and bad will emerge, the main problem for contractors and PCTs will be uncertainty. Against a background of proposed changes to supervision, control of entry and pharmacy services as a whole, the new contract is a leap into the dark. Compared with GPs, who had a new contract in 1990 followed by the heavily evaluated personal medical services scheme before they started their latest negotiations, community pharmacists are making major changes with minimal experience and knowledge. As a result, the effects of the new contract for patients, contractors, PCTs and community pharmacy as a whole are simply unknown.

In response to this worrying situation, we conclude that the Government should pilot the prototype contract in several PCTs before pharmacists are asked to move to this unfamiliar place.

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